VERMONT HEALTH CONNECT
Find the plan that's right for you.

Small Business
Health coverage application for EMPLOYERS

APPENDIX A

Business Name: _____

Employer Identification Number (EIN): _____

Business Type: ◯ **Non-Profit** ◯ **For-Profit**

Primary Worksite Phone (XXX-XXX-XXXX): _____

Contact Person's Name: _____

Contact Preference: ◯ **Work phone** ◯ **Home phone** ◯ **Cell phone** ◯ **Email**

Enrollment Period Preference

Please review the information for the available enrollment periods, and select which you would like benefits to start for your employees. Please note: Employers who select plans between December 1 and December 31 may get January 1 coverage, but they might not receive cards and plan information in January. This means an employee may need to pay more out-of-pocket initially, and then seek reimbursement, and might encounter other complications. Registering by November 30 is the best way for employers and employees to ensure a timely and convenient experience.

Options	For Benefit to be Effective	Employer Should Register by	Employees Should Select Plans from
◯ #1	1/1/14	11/30/13	10/1/13 – 11/30/13
◯ #2	2/1/14	12/31/13	10/1/13 – 12/31/13
◯ #3	3/1/14	1/31/14	10/1/13 – 1/31/14

Medical Plan Selection

Use this document to select the coverage options and contribution levels that you would like to make available to your employees.

Define Carrier Choice

Please indicate which carrier(s) you would like to offer your employees. Please note carrier choice must be the same for all employee groups.

◯ MVP and BCBSVT

◯ MVP Only

◯ BCBSVT Only

On the next two pages, you will define your employee groups and contribution amounts by group. Please identify each group and then within each group identify each employee by their last name, and include social security number, average hours worked per week and marital status. If you have more than one group you will need to photocopy page 2

and 3 for each additional group. If you need to add more employees on the group you name below please photocopy blank page 2, and add the rest on the copy.

Please note: Employers are responsible for ensuring compliance with all state and federal labor laws regarding discrimination and offers of benefits and coverage. There may also be tax consequences associated with these decisions. If you have questions or concerns about fair labor standards, please contact U.S. Department of Labor toll free at (866) 487-2365.

Define Employee Group

Group Name: _____

Will this group contain full-time employees? ◯ Yes ◯ No

Employee Last Name	Social Security Number	Average Hours Worked Per Week*	Annual Salary*

Employee Last Name	Social Security Number	Average Hours Worked Per Week*	Annual Salary*

*Employee Salary and Average Hours Worked are required fields. If you do not wish to provide this information, please enter "0" in the form.

Employee Coverage Options

Employers have the option of extending group coverage to employees and their families. Would you like to offer family coverage to your employees? ◯ Yes ◯ No

Define Contribution Amounts

Please define the contribution that you would like to offer to this group of employees.

You may contribute a flat dollar amount or a percentage. If you choose to contribute a percentage, you will select the reference plan on the next page. A reference plan is the plan in which your employer contribution is based.

Employer Contributions	Single	◯ Dollar (indicate $) ◯ Reference Plan (indicate % and select plan below)	$ %
	Couple	◯ Dollar (indicate $) ◯ Reference Plan (indicate% and select plan below)	$ %
	Parent and Child(ren)	◯ Dollar (indicate $) ◯ Reference Plan (indicate% and select plan below)	$ %
	Family	◯ Dollar (indicate $) ◯ Reference Plan (indicate% and select plan below)	$ %

Select a Reference Plan

If you have chosen the reference plan option, please select it below. The chosen reference plan will apply to all groups and for all employee dependents.

◯ MVP VT Vitality Platinum Standard	◯ BCBSVT Platinum Standard
◯ MVP VT Vitality Gold Standard	◯ BCBSVT Gold Standard
◯ MVP VT Vitality Silver Standard	◯ BCBSVT Silver Standard
◯ MVP VT Vitality Bronze Standard	◯ BCBSVT Bronze Standard
◯ MVP VT Vitality Silver HDHP *can be paired with a HSA*	◯ BCBSVT Silver HDHP *can be paired with a HSA*
◯ MVP VT Vitality Bronze HDHP *can be paired with a HSA*	◯ BCBSVT Bronze HDHP *can be paired with a HSA*
◯ MVP Vitality Plus Gold HMO 500 Non-Standard	◯ BCBSVT Gold Blue Rewards Non-Standard
◯ MVP Vitality Plus Silver HMO 1700 Non-Standard	◯ BCBSVT Silver Blue Rewards Non-Standard
◯ MVP Vitality Plus Bronze HMO 3000 Non-Standard	◯ BCBSVT Bronze Blue Rewards CDHP Non-Standard

Employee Notification Preference

Please select how you would like to receive and communicate information about the Exchange to your employees. Once your enrollment is processed and approved you will be able to print or email employee notification letters.

Please select the method to notify employees: ◯ PDF ◯ Email

Dental Plan Selection

Please complete the following if you are interested in offering dental coverage to your employees. A summary of the dental options available to your employees is included below for your information. Please note: Employers are responsible for ensuring compliance with all state and federal labor laws regarding discrimination and offers of benefits and coverage. There may also be tax consequences associated with these decisions. If you have questions or concerns about fair labor standards, please contact U.S. Department of Labor toll free at (866) 487-2365.

Vermont Health Connect Dental Coverage Options

Insurance Carrier	DELTA DENTAL Northeast Delta Dental	DELTA DENTAL Northeast Delta Dental
Plan Type	PPO	PPO
AV Value, if applicable	85.10%	71.90%
Plan Name	Dental with Pediatric High Option	Dental with Pediatric Low Option
Co-Insurance	Coinsurance	
Routine Dental Services (Adult)	0%	
Dental Check – Up for Children	0%	
Orthodontia – Child	50%	
Major Dental Care – Child	50% after deductible	
Basic Dental Care – Child	30% after deductible	
Major Dental Care – Adult	50% after deductible	
Basic Dental Care – Adult	30% after deductible	
Coinsurance shown will automatically convert to 0% for an enrollee under the age of 21 once the Plan Year Out-of-Pocket Maximum for such enrollee is reached. Coinsurances will reset to those shown above on the first day of each new Plan Year.		
Annual Deductibles And Costs		
Maximum Out of Pocket	$1,000	$1,000
Deductible	$50	$625
Annual Maximum (over 21 years of age)	$1,500	$1,500
Waiting Period for Major Coverage (over 21 years of age)	6 Months	6 Months

Please note:

- The dental plan tier definitions differ from the medical plan tiers.
- Pediatric dental benefits are embedded in all medical plans through Vermont Health Connect. Pediatric dental coverage is available through the last day of the benefit year they turn 21.
- There is a 6-month waiting period for Major Dental Care – Adults only.

Monthly Rates			
Tier	**Tier Definition**	**Adult Plan with High Pediatric Option**	**Adult Plan with Low Pediatric Option**
Individual	One Person – the subscriber, must be an adult	$46.93	
Two Person	A couple (two persons age 21+ who are married to each other or in a civil union, according to the rules of Vermont), or an adult (21+) with an adult child age 21 through 26	$89.62	
Single Head of Household with one or more children	One adult subscriber (age 21+) and one or more dependent child(ren), under the age of 21	$122.12	$110.74
Family	A couple (two persons age 21+ who are married to each other or are in a civil union, according to the rules of Vermont) with child(ren) up to age 26, or an adult subscriber (age 21+) with two or more children, at least one of whom is an adult child age 21 through 26	$165.34	$160.34
Pediatric Only *	One person – must be a child under the age of 21	$38.64	$32.79

*Notes:

- Children eligible for Pediatric Only through the last day of the benefit year they turn 21
- Dependent children include: biological children, adopted children, step-children, and children for whom subscriber is legal guardian

Dental Plan Selection

Please select the plan you wish to offer to all employee groups previously defined for medical:

◯ Adult Plan with High Pediatric Option ◯ Adult Plan with Low Pediatric Option

Please select who you will offer coverage to:

◯ Employee Only ◯ Employee plus dependents

Define Employer Contribution Amounts

Please refer to the groups defined for medical which must be the same for dental coverage.

Tier	Employer Contribution	Employer Contribution	Employer Contribution
	Group Name: _____	Group Name: _____	Group Name: _____
Individual	$	$	$
Two Person	$	$	$
Single Head of Household with one or more children	$	$	$
Family	$	$	$
Pediatric Only	$	$	$

Please sign below.

Print name: _____

Signature: _____ Date: _____

Mail completed and signed form to:

Vermont Health Connect, 103 South Main Street, Waterbury, VT 05671-8100

For certified application counselors, navigators and brokers only. Complete this section if you are a certified application counselor, navigator or broker filling out this application for somebody else.

PLEASE PRINT

Application start date: _____

First name, middle name, last name & suffix (Jr., Sr., III, etc.) _____

Organization name: _____

ID number (if applicable): _____

Brokers will need to have a Broker Designation Agreement signed and kept by both the client and the broker.